

(2) Operated with other departments of the provider under common licensure, governance and professional supervision.

(b) *Payment to independent RHCs and freestanding FQHCs that are authorized to bill under the reasonable cost system.*

(1) RHCs and FQHCs that are authorized to bill under the reasonable cost system are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. This rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS.

(2) The amount payable by the MAC for a visit is determined in accordance with paragraphs (e)(1) and (2) of this section.

(c) *Payment to FQHCs that are authorized to bill under the prospective payment system.* A FQHC that is authorized to bill under the prospective payment system is paid a single, per diem rate based on the prospectively set rate for each beneficiary visit for covered services. This rate is adjusted for the following:

(1) Geographic differences in cost based on the Geographic Practice Cost Indices (GPCIs) in accordance with section 1848(e) of the Act and 42 CFR 414.2 and 414.26 are used to adjust payment under the physician fee schedule during the same period, limited to only the work and practice expense GPCIs.

(2) Furnishing of care to a beneficiary that is a new patient with respect to the FQHC, including all sites that are part of the FQHC. A new patient is one that has not been treated by the FQHC's organization within the previous 3 years.

(3) Furnishing of care to a beneficiary receiving a comprehensive initial Medicare visit (that is an initial preventive physical examination or an initial annual wellness visit) or a subsequent annual wellness visit.

(d)(1) Except for preventive services for which Medicare pays 100 percent under § 410.152(1) of this chapter, Medicare pays—

(i) 80 percent of the all-inclusive rate for FQHCs that are authorized to bill under the reasonable cost system; and

(ii) 80 percent of the lesser of the FQHC's actual charge or the PPS en-

counter rate for FQHCs authorized to bill under the PPS.

(2) No deductible is applicable to FQHC services.

(e) For RHCs visits, payment is made in accordance with one of the following:

(1) If the deductible has been fully met by the beneficiary prior to the RHC visit, Medicare pays 80 percent of the all-inclusive rate.

(2) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is less than the all-inclusive rate, the amount applied to the deductible is subtracted from the all-inclusive rate and 80 percent of the remainder, if any, is paid to the RHC.

(3) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is equal to or exceeds the all-inclusive rate, no payment is made to the RHC.

(f) To receive payment, the FQHC or RHC must do all of the following:

(1) Furnish services in accordance with the requirements of subpart X of part 405 of this chapter and subpart A of part 491 of this chapter.

(2) File a request for payment on the form and manner prescribed by CMS.

[79 FR 25477, May 2, 2014]

#### § 405.2463 What constitutes a visit.

(a) *Visit—General.* (1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter between a RHC patient and one of the following:

- (A) Physician.
- (B) Physician assistant.
- (C) Nurse practitioner.
- (D) Certified nurse midwife.
- (E) Visiting registered professional or licensed practical nurse.
- (G) Clinical psychologist.
- (H) Clinical social worker.

(ii) Qualified transitional care management service.

(2) For FQHCs, a visit is either of the following:

(i) A visit as described in paragraph (a)(1)(i) of this section.

(ii) A face-to-face encounter between a patient and either of the following:

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(A) A qualified provider of medical nutrition therapy services as defined in part 410, subpart G, of this chapter.

(B) A qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H, of this chapter.

(b) *Visit—Medical.* (1) A medical visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

- (i) Physician.
- (ii) Physician assistant.
- (iii) Nurse practitioner.
- (iv) Certified nurse midwife.
- (v) Visiting registered professional or licensed practical nurse.

(2) A medical visit for a FQHC patient may be either of the following:

- (i) Medical nutrition therapy visit.
- (ii) Diabetes outpatient self-management training visit.

(3) *Visit—Mental health.* A mental health visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

- (i) Clinical psychologist.
- (ii) Clinical social worker.
- (iii) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

(c) *Visit—Multiple.* (1) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the patient—

(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;

(ii) Has a medical visit and a mental health visit on the same day; or

(iii) Has an initial preventive physical exam visit and a separate medical or mental health visit on the same day.

(2) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, Medicare pays RHCs and FQHCs for more than 1 visit per day when the conditions in paragraph (c)(1) of this section are met.

(3) For FQHCs that are authorized to bill under the reasonable cost system, Medicare pays for more than 1 visit per

day when a DSMT or MNT visit is furnished on the same day as a visit described in paragraph (c)(1) of this section are met.

(4) For FQHCs billing under the prospective payment system, Medicare pays for more than 1 visit per day when the patient—

(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day; or

(ii) Has a medical visit and a mental health visit on the same day.

[79 FR 25478, May 2, 2014]

**§ 405.2464 Payment rate.**

(a) *Determination of the payment rate for RHCs and FQHCs that are authorized to bill on the basis of reasonable cost.* (1) An all-inclusive rate is determined by the MAC at the beginning of the cost reporting period.

(2) The rate is determined by dividing the estimated total allowable costs by estimated total visits for RHC or FQHC services.

(3) The rate determination is subject to any tests of reasonableness that may be established in accordance with this subpart.

(4) The MAC, during each reporting period, periodically reviews the rate to assure that payments approximate actual allowable costs and visits and adjusts the rate if:

(i) There is a significant change in the utilization of services;

(ii) Actual allowable costs vary materially from allowable costs; or

(iii) Other circumstances arise which warrant an adjustment.

(5) The RHC or FQHC may request the MAC to review the rate to determine whether adjustment is required.

(b) *Determination of the payment rate for FQHCs billing under the prospective payment system.* (1) A per diem rate is calculated by CMS by dividing total FQHC costs by total FQHC daily encounters to establish an average per diem cost.

(2) The per diem rate is adjusted as follows:

(i) For geographic differences in the cost of inputs according to § 405.2462(c)(1).